**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH**

# REVIEW OF THE INCOME MAINTENANCE ADMINISTRATION ENROLLMENT/ELIGIBILITY VERIFICATION PROCESS FOR THE DC HEALTHCARE ALLIANCE PROGRAM

BERT SMITH & Co.

Certified Public Accountants and Management Consultants

**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH**

REVIEW OF THE INCOME MAINTENANCE ADMINISTRATION
ENROLLMENT/ELIGIBILITY VERIFICATION PROCESS
FOR THE DC HEALTHCARE ALLIANCE PROGRAM

## TABLE OF CONTENTS

BERT SMITH & Co.

# INDEPENDENT ACCOUNTANTS' REPORT ON APPLYING AGREED UPON PROCEDURES

Mr. Robert Maruca
Department of Health
Health Safety Net Administration
District of Columbia

We have performed the procedures enumerated below, which were agreed to by the District of Columbia Department of Health (DOH) and Bert Smith & Co. solely to assist DOH with an independent review of the Income Maintenance Administration's (IMA) compliance with the enrollment and eligibility requirements for the D.C. Healthcare Alliance Program (Alliance) for the period of June 1, 2006 through November 16, 2007.

This engagement to apply agreed-upon procedures was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the specified users of the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

## SCOPE OF REVIEW

Bert Smith & Co. performed a review of the IMA enrollment/eligibility process used by the DOH as it relates to the enrollment of recipients in the Alliance. The review was performed in two phases.

The initial phase of this review included the following procedures:

- Reviewed the policies and procedures for enrollment and recertification for the Alliance Program, including:
  - The new policy regarding enrolling the head of household vs. the old policy of enrolling the individual member;
  - The policy of automatically enrolling TANF and food stamp recipients;
  - The policies regarding verification of applicant documentation;
  - The transfers of recipients back and forth between the Alliance and Medicaid;
  - The processing of individuals for Medicaid waiver programs;
  - Recertification procedures;
  - Monthly reports showing enrollment statistics;
  - The timeliness of the enrollment process.
- Reviewed the case files to determine if adequate authorizations, income verifications, and supporting documentation were maintained;

- Identified whether there is adequate classification of homeless recipients, and whether there is follow-up with shelters to verify the homeless status;
- Identified whether there are procedures to timely transfer eligible recipients from the Alliance into the Medicaid Program;
- Identified whether there is a system in place to verify residency and to minimize the risk that applicants who are not D.C. residents will be enrolled in the program;
- Reviewed the systems and procedures used to process Alliance recipients and determine if adequate controls are in place.

The procedures in the second phase were as follows:

- Identified whether ineligible applicants were being enrolled in the Alliance;
- Documented the quantifiable scope, if found, along with a categorical breakdown of ineligible enrollees;
- Determined whether improper enrollment was due to an incorrect eligibility determination or was a product of District Statutes and/or Rules. The review distinguished whether it was the result of IMA worker error or a misrepresentation of facts by the applicant;
- Identified other potential quantifiable problematic trends, or findings related to Alliance enrollment.

## SUMMARY OF RESULTS

As a result of our review of the enrollment and eligibility, we made observations regarding the enrollment process, policies and procedures, and systems which are summarized in the following report.

We made recommendations to these observations that would support improvements which are discussed in detail in this report.

We were not engaged to, and did not perform an audit, the objective of which would be the expression of an opinion on the specific elements, accounts or items. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported.

This report is intended solely for the use of the Department of Health, Health Care Safety Net Administration and the Income Maintenance Administration and is not intended to be, and should not be, used by anyone other than these specified parties.

January 21, 2007

Bert Smith & Co.

# I. EXECUTIVE SUMMARY

The Health Care Safety Net Administration (HCSNA) within the Department of Health was established to oversee and ensure that eligible uninsured residents of the District receive access to appropriate quality health care with an emphasis on disease prevention and community-based primary care through an integrated, cost-efficient, and culturally appropriate system. The HCSNA has oversight and monitoring responsibility over the Alliance, a public-private partnership between the District and private healthcare providers in the District.

Effective June 1, 2006 the eligibility determination function that was previously performed by Chartered Health Plan was transferred to the Income Maintenance Administration (IMA) in the Department of Human Services.

Bert Smith & Co. was engaged by the District of Columbia Department of Health (DOH) solely to assist the DOH in conducting a review of its enrollment and eligibility process for the Alliance Program in order to evaluate its compliance with DC statutes and Alliance rules.

As a result of our review of the enrollment and eligibility, we made observations regarding the enrollment process, policies and procedures, and systems, which are summarized below:

- Enrollment policies and procedures should be reviewed and enhanced (Observation #1);
- Documentation in the case files should be improved (Observation #2);
- Policies regarding the homeless recipients should be improved (Observation #3);
- Procedures to timely transfer eligible recipients from the Alliance into other programs should be improved (Observation #4);
- Procedures used to verify residency should be improved (Observation #5);
- Internal control over the systems used to process Alliance recipients should be improved (Observation #6);
- Improvements are needed in the enrollment procedures as identified in an analysis of sample files (Observation #7).

Each of these subject areas is summarized in the matrix on the following pages. The detailed observations and recommendations are presented in Section IV: Observations and Recommendations.

Our recommendations regarding these policies are intended to improve controls over the enrollment/eligibility process and system-related payments.

IMAs responses to these observations and recommendations are included in the Appendix.

## OBSERVATION #1: ENROLLMENT AND RECERTIFICATION POLICIES AND PROCEDURES

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *ELIGIBILITY VERIFICATIONS:* Verification procedures are not being performed consistently with the requirements of the regulations. There is a risk that applicants may misrepresent facts to obtain eligibility and the misrepresentation may go undetected. | The code of the District of Columbia, regulation CDCR §3304.1-§3304.8, requires that verification procedures be performed in determining residency (§3304.4 and §3304.8), income (§3304.5), and countable resources (§3304.6). IMAs procedures do not meet these standards. | Verification procedures need to be enhanced to ensure that information and documents are authenticated prior to eligibility. The Maryland benefit website should be checked for all applicants. Steps should be taken to obtain access to the Virginia benefit website. Whenever possible, electronic authentication through other agencies should be performed.<br><br>Supervisory personnel should ensure that all verification procedures required by the regulations and all written policies and procedures for verifications are followed. |
| *NEED FOR AN EXPANDED INTERNAL VERIFICATION FUNCTION:* Intake workers have time constraints and large caseloads that may prevent them from performing comprehensive verifications. The risk is that an intake worker may not perform adequate verifications or may not make a referral to investigations, resulting in inappropriate eligibility enrollees in the program. | Adequately conducting intake interview, reviewing an application and performing sufficient verification on the application could be restricted because of time constraints on the intake workers. In addition, these intake workers may be inadequately trained in the best procedures for conducting verifications or determining when investigation should be conducted. | IMA should consider establishing an internal verification function separate from the intake function that would conduct verifications and make referrals to the investigation unit when required. The verifiers should be specifically trained in adequate verification procedures and should meet the 45-day deadline for making a determination on an application. |
| *TIMELY INVESTIGATIONS:* Applications that are referred to the Investigation Unit are not investigated in a timely manner. Because of this, IMA makes the applicant eligible based on information presented and later reevaluates eligibility based on an investigation. There is a risk that the District may pay benefits for someone who misrepresented facts to obtain eligibility. | In making eligibility determinations, IMA is required by the regulations to follow the timeframe requirements required under the Medicaid Program, see CDCR §22-3305.2 which refers to 42 CFR § 435.911. Under these regulations, IMA is permitted to exceed the 45 day rule under certain circumstances. | IMA should assess the staffing of its Investigation Unit so that the 45-day time period can be met when an investigation is needed. IMA should also assess the application process so that there is adequate opportunity for verifications and investigations if required. In situations where there is a need for an investigation that cannot be met within 45 days, the eligibility determination should be deferred until the completion of the investigation based on 42 CFR § 435.911(c)(1) |

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| | We found that IMA does not conduct all investigations prior to making an eligibility determination. | which allows exceptions to the 45 day rule. This change would reduce the payments for applicants who misrepresent facts in order to obtain eligibility. |
| *CITIZEN/ALIENAGE STATUS:* The current policy allows applicants to self-describe their citizenship status, thus preventing an evaluation of the applicant for other federal programs. IMA is restricted in its ability to perform further inquiry of an applicant who indicates a citizenship status of 'other.' This restriction reduces IMAs ability to explain the available programs and conduct a complete assessment of the applicant. The potential risk is that individuals are unnecessarily placed in the Alliance program because the qualifying questions have not been asked. | IMA follows the Mayor's Order 92-49 published in 1992 which prevents IMA from asking questions concerning a person's citizenship background. | The policy of not asking sufficient questions to make an adequate eligibility determination should be reassessed to determine whether IMA should be allowed to perform further inquiry of applicants who check 'other' as a citizenship/alienage category on their applications. These applicants may not understand that they may be eligible for other programs. IMA should take this opportunity to provide further explanations of the available programs. |
| *RECERTIFICATION PROCESS:* The current recertification process does not require verification procedures to determine continued eligibility for a recipient. Additionally, IMA does not regularly perform electronic checks of benefit databases in neighboring states at recertification. The risk is that the recertification process may not identify eligibility issues and may not be conducted in a timely manner. | The regulations require that an applicant must recertify on an annual basis to maintain eligibility in the Program. IMA uses the same requirements as Medicaid for recertification, where recertification can be conducted by mail, fax, or in person. The recipient is required to return a signed two-page questionnaire where the recipient answers questions either 'Yes' or 'No' regarding changes in his or her situation. No documentation is required except when the signer self-declares a change or has earned income. | The recertification process should be subject to similar verification procedures as the application process. At a minimum, IMA should re-verify the address, and the electronic benefit databases in other States should be checked at recertification. |

## OBSERVATION #2: MAINTENANCE OF CASE FILES

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *INACCURACIES IN THE ACEDS DATA AND PAPER RECORDS:* We identified a number of fields in the ACEDS database where it appears that the data is either missing or inaccurate. We also identified errors in the paper files maintained for the recipients. The risk is that inaccurate information may result in improper eligibility determinations and payments. | We reviewed the accuracy of the data in the ACEDS fields and paper files that were provided to us, and found situations where there appeared to be duplicate cases; where data appeared to be entered incorrectly; and where documents were missing in the files.<br><br>We reviewed the written training materials that were provided to us for the Alliance Program and determined that data entry procedures were not covered in the written training materials. | IMA should review all fields for its active recipients and ensure that the information in all of the fields is accurate; and that all duplicates cases are closed. HCSNA should recoup duplicate payments. IMA should also review its paper files for completeness. IMA should also consider the use of the homeless indicator to identify homeless individuals in the program.<br><br>IMA should expand its instructions on how the data should be entered into ACEDS and stress the need for accuracy. IMA supervisors should review the data entries in the fields as part of the process of approving an application. |
| TRAINING AND SUPERVISION: We found existing procedures that were either not consistent with or missing from the IMA training materials and policy and procedure manuals. The risk is that improper determinations may be made and files may be inadequate if staff is not provided with proper reference or training materials. A lack of complete written procedures could also result in an inability to provide adequate supervision to intake workers. | IMA has written policies, procedures, and training materials that discuss many aspects of the Alliance requirements, but do not include all of the desktop steps necessary to accurately post the recipient data in the database. We identified several examples of these missing procedures. | IMA should consider expanding its training materials and policy and procedure manual to include all policies and procedures currently in place, as well as detailed instructions on accurately entering the records in the ACEDS database. All intake workers should receive this training, and supervisors should review the accuracy of database entries and the completeness of the paper files. |

## OBSERVATION #3: CLASSIFICATION OF HOMELESS RECIPIENTS AND VERIFICATION OF THEIR HOMELESS STATUS

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *ADDITIONAL VERIFICATIONS FOR HOMELESS INDIVIDUALS:* The regulations regarding verifications for homeless individuals are not specifically defined. The homeless population has no requirement for producing proof of residency. In our review of the 359 sample cases, there were inconsistencies in the case documentation and indications that recipients had addresses outside of the District in four homeless cases. The potential risk is that without well-defined procedures, verifications may not be performed in a consistent manner. | CDCR §3304.8 states that when the applicant or enrollee indicates that he or she is homeless, IMA may request verification of residency if it has substantial reason to believe that the applicant or enrollee is not homeless or is not a District resident.<br><br>Although IMA procedures comply with the Alliance rules, this regulation has not been clarified in writing to provide guidance on the circumstances or conditions that would require additional verifications of residency, but rather, it has been left up to the judgment of the intake worker when further verifications are required or when a case should be referred for investigation. Management's clarification would help ensure that intake workers make consistent determinations. | The policies and procedures should be expanded and more closely defined in writing to include specific circumstances where additional verification could be required for those who declare themselves to be homeless. |
| *'INTENT TO RESIDE' CLAUSE IN THE REGULATIONS:* Currently, a written declaration of a homeless individual's intent to reside in the District is not required. The potential risk is that individuals who do not intend to reside in the District could still qualify for benefits. | CDCR §3304.7 states that IMA should not routinely require further verification of residency for homeless applicants if the applicant attests that he or she is homeless; lives in the District of Columbia; and intends to remain in the District of Columbia. | IMA should consider revising the application to include a written attestation that conforms to §3304.7. |

## OBSERVATION #4: TIMELY TRANSFERS OF ELIGIBLE RECIPIENTS FROM THE ALLIANCE INTO OTHER PROGRAMS

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *MEDICAID/MEDICARE-ELIGIBLE RECIPIENTS:* IMA does not consistently transfer U.S. citizens over 65 out of the program and into Medicaid/Medicare in a timely manner. If the transfer is not timely performed, there is an additional cost to the program that must be recouped from the MCO. | Each recipient who is a U.S. citizen should be reviewed for eligibility in Medicaid or Medicare and transferred out on his/her 65th birthday if found to be eligible. We noted that not all of these individuals qualify for these programs and some will remain in the Alliance Program. We identified delays in these transfers. | IMA should review all U.S. citizens who are over 65 to determine if they qualify for Medicaid/Medicare. In addition, IMA should review all recipients who are 64 and ensure that their recertification dates correspond to their birthdays.<br><br>IMA should set up systems and procedures to ensure that all qualified recipients are routinely transferred out of the program in a timely manner so that the requirement for recoupment is either minimal or not necessary. |
| *MAXIMIZE MEDICAID REIMBURSEMENT FOR THE CHILDLESS ADULTS AGED 50-64 WAIVER PROGRAM:* Prior to February 2007, IMA did not transfer citizens between the ages of 50 and 64 to the Medicaid Waiver Program in a timely manner. If the transfers are not timely performed, there is an additional cost to the program that must be recouped. | The District has available a Section 1115 Medicaid waiver to allow childless adults between the ages 50 to 64 with specified income limits to enroll in the Medicaid Program, with a cap of 1,650 participants. Although available in June 2006, we found that IMA did not start transferring Alliance Program participants who were eligible for the waiver program until February 2007. | We recommend that IMA establish policies and procedures to ensure the timely transfer of eligible participants to the Medicaid Program. |

## OBSERVATION #5: RESIDENCY VERIFICATIONS

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *ADDRESS MONITORING:* IMAs current procedures do not require the monitoring of addresses claimed by recipients. We identified situations where a large number of people claimed to live at the same address. The range of questionable addresses is from 33 recipients at a single address to a low of 7 recipients at an address. There is a risk that certain individuals who are not qualified based on residency may provide inaccurate residency information in order to obtain benefits. | The application form requires the disclosure of all individuals who reside at an address. We identified situations where it appears that large numbers of recipients were claiming the same address. A detailed review of a sample showed that the individuals at certain addresses did not report the other residents. | IMA should consider investigating the addresses for individuals where unusually high numbers of recipients reside in order to determine whether recipients are inappropriately claiming an address. IMA should consider having a regular procedure for checking the database for the number of people claiming to live at an address and should consider conduct periodic investigations. |
| *RESIDENCY LETTER:* We found letters with incomplete residency information. These letters increase the risk of misrepresented or omitted facts in the application and the possibility of these facts going undetected. | CDCR §3304.2.3 permits the use of a verifiable letter to confirm residency. An applicant must present a letter from a verifiable source confirming that the applicant resides in the District.<br><br>The residency verification process is limited because the current policy does not require IMA to have a standardized form for identifying residency information. IMA has stated that the verification letter is designed to establish residency only at the time of application and does not represent a verification beyond this initial date. | IMA should consider improving the residency letter by making it a standardized form which includes key fields that must be completed prior to the approval of eligibility. The key fields could also make the form easier to verify and would strengthen and enhance the documentation in instances where the letter is the only source of residency verification.<br><br>We also recommend that an attestation clause be used in the letter. This clause would state that the signer is providing the information so that the application can receive benefits intended only for District residents, and that the information is true and correct, and that the information is being provided under penalty of perjury.<br><br>In addition, IMA should ensure that verification procedures are performed on all residency letters prior to approval of eligibility. |

## OBSERVATION #6: SYSTEMS AND PROCEDURES USED TO PROCESS ALLIANCE RECIPIENTS

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *RECONCILING PAYMENTS TO THE ACEDS DATA SYSTEM:* IMA and HCSNA do not perform a regular comparison of payments to ACEDS data. We compared the November 2007 payments to the ACEDS database and identified situations where a match did not occur. We found 159 recipients whose names were not in the ACEDS database. These recipients received 214 payments out of 47,709 payments for November 2007. The risk is that errors in the ACEDS system or the payment system may go undetected and payments may continue. | IMA explained that a total of 275 names were not included in the database of 73,001 provided to us due to a programming error and/or due to an error in the data entry. The 159 recipients were part of this group. IMA also explained that 48 out of the 159 people were eligible for the Alliance in November.<br><br>HCSNA reviewed 98 of the 159 recipients missing in the database and identified that 22 recipients were active in the Alliance; 59 had been transferred to Medicaid with retroactive eligibility; 14 recipients had data entry issues and therefore did not show as Alliance recipients when they should have; and 3 were ineligible and payments were recouped on subsequent remittance advices. | The District should consider implementing a procedure for a regular comparison of the payment database and the eligibility database to identify mismatches and potential errors. |
| *RECIPIENTS WITH ELIGIBILITY PERIODS NOT IN CONFORMITY WITH THE ESTABLISHED BENEFIT PERIOD:* We obtained the eligibility files from the ACEDS system that maintains the eligibility data for recipients and reviewed the eligibility periods for active recipients. We determined that 15,762 recipients out of 43,452 (36.3%) had eligibility periods that differed from the 4-month and 12-month eligibility periods identified in the regulations and by IMA. When the eligibility span differs from the regulations, the risk is that payments may be made for periods where a recipient should no longer be in the program. | The regulations stated that the eligibility (benefit) period can not exceed 12 months.<br><br>We found that 15,762 recipients out of 43,452 where the records vary from the 4-month and 12-month eligibility periods. | IMA should review the eligibility periods for the identified cases. It should update eligibility dates; and review recertification dates so that they conform to the 4-month and 12-month policy.<br><br>IMA should consider implementing a procedure for a regular review of eligibility periods to identify situations where the benefit period does not conform to the regulations. |

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *PAYMENTS THAT APPEAR TO BE MADE FOR INACTIVE RECIPIENTS:* We compared the November 2007 payments to the ACEDS database and identified situations where a payment was made for recipients who appear to be inactive. We found 583 payments out of 47,709 payments where the records indicate that the eligibility period had expired and there was also a recertification date in the past, or the case had been closed in a previous month and a payment was still made for November 2007. Situations where the payments are made after the eligibility period has expired indicate a risk that over payments may be made to the MCO. | We analyzed the November 2007 payments in order to ascertain whether any payments were made for recipients where the eligibility period had already expired as indicated by either the end-date or the recertification date. Situations where the payments are made after the expiration of benefits require efforts to recoup the payments. | IMA and HCSNA should review these records and close out all cases where the eligibility period has expired. HCSNA should attempt to recoup payments. |
| *MORE THAN ONE PAYMENT WAS MADE FOR A RECIPIENT:* We analyzed the November 2007 payment file to identify situations where multiple payments were made for a recipient. We found 249 recipients representing 1,409 payments where the payments were in excess of three months, where three months should be the maximum. Situations where the payments exceed the time limits in the policies and procedures indicate a risk that over payments may be made to the MCO. | We found 249 recipients representing 1,409 payments where the payments were in excess of three months.<br><br>HCSNA reported that they reviewed 49 of the cases and identified 502 situations requiring recoupment. | IMA and HCSNA should review these multiple payments and ensure that extra payments are not made beyond the allowable policy. HCSNA should continue to recoup payments. |

## OBSERVATION #7: IMPROVEMENTS NEEDED IN THE ENROLLMENT POLICIES AND PROCEDURES

| ISSUE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| *PROPER CLASSIFICATION OF APPLICANT'S MEDICAL ELIGIBILITY:* Out of the sample of 359, we noted two instances where the documents in the case file suggest that individuals who are in the Alliance Program could have qualified for Medicaid. The potential risk is that individuals may be placed in the Alliance Program that could have been in Medicaid. | Regulation §3304.2 states that eligibility for the Alliance is limited to residents who are not eligible for Medicaid.<br><br>We noted two instances where the documents in the case file suggest that individuals who are in the Alliance Program could have qualified for Medicaid. | IMA should consider reviewing its enrollment procedures and its case review procedures in an effort to reduce the risk of incorrect enrollment due to improper IMA determinations. |
| *SUFFICIENCY OF DOCUMENTATION IN SUPPORT OF ELIGIBILITY:* Our review of the sample files indicates inadequate documentation was maintained in case files in support of enrollment decisions. The risk is that there could be incorrect enrollment determinations and errors or misrepresentations of fact by applicants and it cannot be determined by reviewing the files. | Regulation §3304.4(a) allows a valid motor vehicle operator's permit issued by the District's Department of Motor Vehicles for residency verification. Regulation §3304.4(c) allows a lease for residency verification.<br><br>Out of a sample of 359, we noted instances where these required documents were missing from the case files. | IMA should consider more closely adhering to its policies and procedures over file maintenance and should encourage uniform file organization. We suggest that they consider using a checklist of recipient information. In addition, management should also consider the following:<br>▪ Supervisory staff should conduct case reviews to identify areas prone to repeated errors and to ensure caseworker accountability;<br>▪ Providing regular comprehensive training sessions for eligibility intake workers in order to identify and address potential risk areas;<br>▪ Performing random statistical case file reviews to determine completeness of files and accuracy of enrollment. |

# II. BACKGROUND

The District of Columbia Healthcare Alliance Program (the Alliance) is a publicly financed health care delivery system that serves as a safety net for District residents who are uninsured or underinsured and do not qualify for Medicaid. The Health Care Safety Net Administration (HCSNA) is within the Department of Health (DOH) and has oversight and monitoring responsibility for the program.

The Alliance Program was originally enacted through Title 22, Chapter 33 of the D.C. Municipal Regulation. The Statutory Authority for this regulation is D.C. Code §47-392.7. Prior to June 1, 2006, an applicant was required to apply in person at one of the locations for the Alliance Clinics; present identification; and fill out a form that was exclusively used for the Alliance Program. Under this arrangement, medical assistance was determined for each individual, and those who had some form of private insurance were ineligible.

Effective June 1, 2006, new regulations were enacted (CDCR 22-3301 et. al.) that brought about two important changes in the program and in the eligibility requirements. First, management of the eligibility process was transferred to the District's Income Maintenance Administration (IMA), a division of the Department of Human Services. IMA also provides enrollment for other assistance programs and the Alliance enrollment was combined with their enrollment procedures.

Second, the Alliance Program transitioned from a "fee-for-service" to a "managed-care" model. Under the former program, costs were charged as they were incurred for medical services, with a small enrollment fee for program maintenance. Under the new model, a monthly payment is paid to a Managed Care Organization (MCO) for all enrollees regardless of medical needs. Coverage is for a maximum of twelve months with an annual recertification process.

On June 1, 2006, IMA added the processing of applications for the Alliance Program to their existing processing services for Temporary Assistance for Needy Families (TANF), Food Stamps, Medicaid, Burial Assistance, Refugee Cash Assistance, Interim Disability Assistance and General Assistance for Children programs. IMA operates seven decentralized service centers, a call center, and seventeen outstations in the District to process these applications.

IMA also implemented certain Medicaid eligibility rules adopted by the District for the Alliance and began use of a combined application form that facilitates enrollment in each of the programs. IMA uses the Automated Client Eligibility Determination System (ACEDS) to process these applications and to track recipient information. The ACEDS system interfaces with the District's Medicaid Management Information System (MMIS) which is used to process the Alliance Program payments made to the MCOs. On a nightly basis, changes to the ACEDS records are uploaded to the MMIS.

The Alliance enrollment has increased from 34,907 recipients to 45,807 for the review period of June 2006 to May 2007, an increase of 31.2% for one year. During the previous period, June 2005 through May 2006, the enrollment increased from 27,336 to 33,190, or an increase of 21%. As of November 2007, the enrollment was 46,490.

# III. METHODOLOGY

## Initial Procedures

We obtained an understanding of the regulations that govern the Alliance Program through the most recent enactments. These regulations were CDCR 22-3301 through 3306 and CDCR 22-3399. We obtained an understanding of the eligibility policies and procedures through reviewing written policy and procedure documents, and obtained an understanding of the IMA training and supervisory procedures. Once we had an understanding of the IMA procedures, we submitted our written summary to IMA for review and comment. We incorporated the IMA comments into our final understanding.

We performed a walkthrough of the intake process and obtained an IMA eligibility database of 63,167 and requested certain critical fields for all individuals who were enrolled in the Alliance Program from June 1, 2006 through May 31, 2007. We matched this with a second database identifying all monthly payments made to the Managed Care Organizations on behalf of Alliance recipients paid through June 6, 2007.

We identified the homeless individuals by matching the database addresses with the addresses of homeless shelters in the District and also identified homeless individuals who used IMA office addresses as their mailing address. After eliminating the homeless recipients, we identified the individuals using the same residential addresses.

We identified whether there were timely procedures to transfer eligible recipients from the Alliance into the Medicaid Program by reviewing transfer information. We identified that the recipients who are given 4-month eligibility periods in order to complete a Medicaid application are identified with a recertification date.

We identified that the recipient addresses are verified through the means identified in the regulations, including obtaining residency letters and/or matching the address with driver's licenses or utility bills.

We used IDEA data extraction software and applied attribute sampling to arrive at a sample size of 360 from the initial database of 63,167 that covered the period June 2006 through May 2007, and reviewed case files for compliance with the eligibility procedures. We determined whether appropriate eligibility determinations were performed by examining the documentation in the case files.

## Expanded Procedures

In the second phase, we obtained a second IMA eligibility database containing 73,001 records and requested certain critical fields for all individuals who were enrolled in the Alliance Program from June 1, 2006 through November 16, 2007, and matched it against a second database identifying all payments made in the month of November 2007 to the Managed Care Organizations on behalf of Alliance recipients.

As a result of this matching process, we identified and analyzed those cases where there was no match, and performed follow-up to determine the reasons for the non-matching payments. We also reviewed the eligibility file to determine whether the eligibility period given to recipients conformed to stated policies.

We identified the homeless individuals by matching the new database addresses with the addresses of homeless shelters in the District and also identified homeless individuals who used IMA office addresses as their mailing addresses. We attempted to match the ACEDS database to a database of homeless individuals kept by the District. This matching could not be accomplished because of differences in the structure of the files. We were able to manually match 50 of the ACEDS names with the homeless database.

We performed an analysis of the residential addresses used by all individuals in the database of 73,001 from June 2006 through November 2007. We excluded addresses associated with homeless recipients to obtain data for an analysis of common addresses. The resulting list was used to build a pivot table to analyze the number of recipients at each address and included recipients with 7 or more recipients at an address. From this we selected a sample of 13 addresses with 83 recipients for further analysis.

We identified whether there were timely procedures to transfer eligible recipients from the Alliance into the Medicaid Program by reviewing transfer information. We identified that the recipients who are given 4-month eligibility periods are identified with a recertification date. We identified that recipients who are approaching the age of 65 are not identified with a code on their birthdays which would result in a timely review.

We identified the following subpopulations from the database of 73,001 that were categorized according to specific attributes. In some situations, recipients fell into more than one sub-population:

- 2,346 out of the 73,001 recipients who were 65 and older based on birthdates, which represented recipients described as U.S. citizens. We then analyzed the closed cases for U.S. citizens to determine how long these recipients were in the Alliance before moving to other programs, and to identify open cases that could be reviewed for transfers to other programs.
- 9,625 out of the 73,001 were identified as the homeless population, based on recipients using publicly funded homeless shelters, private homeless facilities, and IMA addresses.
- 63,376 recipients were identified as using residential addresses by excluding the homeless population from the database of 73,001 as discussed above.
- 1,811 out of 73,001 records were reviewed to determine the possibility of duplicate records. These were identified through a manual review of the database matching the names, birthdates, addresses, and social security number, if available.

In reviewing our sample of 360, we reviewed the eligibility factors by performing an examination of the application and supporting documentation. We reviewed 359 case files because one file was not provided. In cases where the individual presented a letter in support of residency, we attempted to contact the signer of the letter.

On these cases, we performed the following:

- Reviewed the case files to determine the documentation used for eligibility;
- Identified the cases that suggest that the recipient was homeless;
- Identified the cases that had attestation residency letters and provided a breakdown of who signed the letters (friend, relatives, landlord, clergy, etc.);
- Identified 47 questionable cases based on income and residency information which we referred to IMA for further investigation.

We were unable to perform further verifications procedures because we could not gain access to the benefit files for either Maryland or Virginia. IMA was able to check the Maryland benefits database and provided us with their results.

In analyzing the results from this sample, we considered:

- The exact language of the regulations to determine whether an incorrect enrollment determination was made;
- Written IMA policies and procedures that interpreted these regulations;
- The documentation that was in the file that would identify the procedures employed by the intake worker to perform calculations and verifications.

# IV. OBSERVATIONS AND RECOMMENDATIONS

**OBSERVATION #1:**
***Enrollment and Recertification Policies and Procedures***

**1.a. Eligibility Verifications -** Verification procedures are not being performed consistently with the requirements of the regulations. There is a risk that applicants may misrepresent facts to obtain eligibility and the misrepresentation may go undetected.

The code of the District of Columbia, regulation CDCR §3304.1-§3304.8, requires that verification procedures be performed in determining residency (§3304.4 and §3304.8), income (§3304.5), and countable resources (§3304.6).

We determined that IMA does not provide procedures to determine the authenticity of the documents presented and/or other information that is provided, as follows:

- Driver's licenses and other forms of identification are not checked;
- Employment-related income is not confirmed;
- Confirming letters are not required from a homeless shelter;
- Virginia benefits websites are not searched;
- Alien identification number are not always verified and entered correctly;
- Assets values are not verified;
- Members of a household are not compared with other individuals in the program who claim to live at the same address;
- Recipient's address is not independently confirmed.

From our sample, we found 47 cases that we deemed questionable because of verification procedures and referred them to IMA for investigation. Some of the results of their investigation indicated the following:

- One instance out of 359 where a recipient received dual benefits in Maryland from July 2006 through June 2007 and in the Alliance from November 2006 through July 2007.

- One instance out of 359 where a recipient applied for and was determined eligible for medical assistance in the District in November 2006. There was questionable information in the file showing Maryland withholding and inadequate residency information. The recipient was approved for medical assistance in Maryland in January 2007 and food stamps in September 2007;

- One instance out of 359 where IMA stated that it appeared that the recipient alternated between the District and Maryland.

The intake worker is responsible for the review of all documents presented by the applicant and for conducting the initial verification procedures. IMAs verification procedures include the following:

- If a social security number is obtained, the number is validated through a table in ACEDS;

- If an alien registration card is obtained, immigration status can be verified through the Department of Homeland Security's Systematic Alien Verification System (SAVE). When an applicant reports that he/she belongs in a category that may qualify him/her for federal benefits, they are asked to provide alien identification numbers;

- The ACEDS database electronically checks basic address information. The person's address is also checked by confirming the address on a driver's license, utility bill, or rent receipt;

- When a letter is presented that confirms residency, a telephone call is usually placed to the person who wrote the letter. In some instances, this person may also be requested to provide documentation of their residency;

- Social security benefits and some District benefits are verified through updated benefit in ACEDS;

- The applicant's name is checked against other District programs to determine whether the person is receiving other benefits that might overlap with Alliance benefits;

- When circumstances warrant an investigation, the Maryland benefits website is checked to match for applicants who are receiving benefits in Maryland. Current access to the Maryland database is restricted to a few investigators.

**Recommendation:** Verification procedures need to be enhanced to ensure that information and documents are authenticated prior to eligibility. The Maryland benefit website should be checked for all applicants. Steps should be taken to obtain access to the Virginia benefit website. Whenever possible, electronic authentication through other agencies should be performed.

Supervisory personnel should ensure that all verification procedures required by the regulations and all written policies and procedures for verifications are followed.

**1.b. Need for an Expanded Internal Verification Function** - Intake workers have time constraints and large caseloads that may prevent them from performing comprehensive verifications. The risk is that an intake worker may not perform adequate verifications or may not make a referral to investigations, resulting in inappropriate eligibility enrollees in the program.

Adequately conducting intake interview, reviewing an application and performing adequate verification on the application could be compromised because of time constraints on the intake workers. In addition, these intake workers may be inadequately trained in the best procedures for conducting verifications or determining when investigation should be conducted.

**Recommendation:** IMA should consider establishing an internal verification function separate from the intake function that would conduct verifications and make referrals to the investigation unit when required. The verifiers should be specifically trained in adequate verification procedures and should meet the 45-day deadline for making a determination on an application.

**1.c. Timely Investigations** - Applications that are referred to the Investigation Unit are not investigated in a timely manner. Because of this, IMA makes the applicant eligible based on information presented and later reevaluates eligibility based on an investigation. There is a risk that the District may pay benefits for someone who misrepresented facts to obtain eligibility.

In making eligibility determinations, IMA is required by the regulations to follow the timeframe requirements required under the Medicaid Program, see CDCR §22-3305.2 which refers to 42 CFR § 435.911.

42 CFR § 435.911 Timely Determination of Eligibility states:

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed -
    (1) Ninety days for applicants who apply for Medicaid on the basis of disability; and
    (2) Forty-five days for all other applicants.
(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.
(c) The agency must determine eligibility within the standards except in unusual circumstances, for example -
    (1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action....
(d) The agency must document the reason for delay in the applicant's case record.

These regulations require that an eligibility determination must be completed within 45 days from the date of application. IMA conforms to this, however they also allow individuals 45 days to complete the application process. Therefore, when applicants submit their documents close to or on the 45th day and an investigation is required, the limited time remaining does not permit an investigation in a timely manner. Under these circumstances, the applicant is made eligible during the investigation process and a subsequent determination is made.

The Investigation Unit handles all investigations for all IMA programs, and estimates that it normally takes 3-6 months for an investigation. As an average, it recommends closure in approximately 50% of its cases. The most common reason for recommending closure is that a residential address cannot be verified. The IMA Investigation Unit does not keep records of investigations by program, therefore the proportion of investigations related to the Alliance cannot be definitively quantified.

If the Investigation Unit recommends closure of the case, the recipient is given 15 days notice of the pending closure and has the opportunity to ask for a Fair Hearing before the case can be closed. It takes another 15-30 days before a case can be closed. In the meantime, the District has made

payments for a recipient who was not eligible at the inception. This failure to investigate prior to approval of eligibility results in unnecessary payments.

**Recommendation:** IMA should assess the staffing of its Investigation Unit so that the 45-day time period can be met when an investigation is needed. IMA should also assess the application process so that there is adequate opportunity for verifications and investigations if required. In situations where there is a need for an investigation that cannot be met within 45 days, the eligibility determination should be deferred until the completion of the investigation based on 42 CFR § 435.911(c)(1) which allows exceptions to the 45 day rule. This change would reduce the payments for applicants who misrepresent facts in order to obtain eligibility.

**1.d. Citizen/Alienage Status** - The current policy allows applicants to self-describe their citizenship status, thus preventing an evaluation of the applicant for other federal programs. IMA is restricted in its ability to perform further inquiry of an applicant who indicates a citizenship status of 'other.' This restriction reduces IMAs ability to explain the available programs and conduct a complete assessment of the applicant. The potential risk is that individuals are unnecessarily placed in the Alliance program because the qualifying questions have not been asked.

IMA follows the Mayor's Order 92-49 published in 1992 which prevents IMA from asking questions concerning a person's citizenship background.

**Recommendation:** The policy of not asking sufficient questions to make an adequate eligibility determination should be reassessed to determine whether IMA should be allowed to perform further inquiry of applicants who check 'other' as a citizenship/alienage category on their applications. These applicants may not understand that they may be eligible for other programs. IMA should take this opportunity to provide further explanations of the available programs.

**1.e. Recertification Process** - The current recertification process does not require verification procedures to determine continued eligibility for a recipient. Additionally, IMA does not regularly perform electronic checks of benefit databases in neighboring states at recertification. The risk is that the recertification process may not identify eligibility issues and may not be conducted in a timely manner.

The regulations require that an applicant must recertify on an annual basis to maintain eligibility in the Program. IMA uses the same requirements as Medicaid for recertification, where recertification can be conducted by mail, fax, or in person. The recipient is required to return a signed two-page questionnaire where the recipient answers questions either 'Yes' or 'No' regarding changes in his or her situation. No documentation is required except when the signer self-declares a change or has earned income.

Because the Alliance Program does not require the same initial verifications as other programs, IMA needs to design a recertification process that meets the unique demographics and verification procedures in its own program. An example of a unique attribute of the Alliance Program is that it permits the use of letters to verify residency and permits a wider range of identification procedures that other programs.

**Recommendation:** The recertification process should be subject to similar verification procedures as the application process. At a minimum, IMA should re-verify the address, and the electronic benefit databases in other States should be checked at recertification.

**OBSERVATION #2:**
***Maintenance of Case Electronic Records and Files***

**2.a. Inaccuracies in the ACEDS Data and Paper Records** -We identified a number of fields in the ACEDS database where it appears that the data is either missing or inaccurate. We also identified errors in the paper files maintained for the recipients. The risk is that inaccurate information may result in improper eligibility determinations and payments.

We reviewed the accuracy of the data in the ACEDS fields and paper files that were provided to us, and found the following:

- We found 1,811 out of 73,001 records that appear to be duplicate entries for recipients. Of these, many of the duplicate entries were the result of misspelled names and the use of a hyphenated name. Some of these records had overlapping eligibility periods;
- We found 2,194 out of 73,001 records that had alien identification information. Of these, 855 records were found where the alien identification number appeared to be entered incorrectly. Alien numbers should start with an "A" and should have nine digits;
- We found 291 out of 2,194 records where the date the recipient entered the country was entered incorrectly. Most of the dates were missing a digit, or the year was typed incorrectly;
- We found a number of recipient telephone numbers that had missing digits or too many digits;
- We found instances where the apartment numbers were input incorrectly;
- We found 56 files reviewed in our sample where the application or recertification forms were missing.

We reviewed the written training materials that were provided to us for the Alliance Program and determined that data entry procedures were not covered in the written training materials.

**Recommendation:** IMA should review all fields for its active recipients and ensure that the information in all of the fields is accurate; and that all duplicates cases are closed. HCSNA should recoup duplicate payments. IMA should also review its paper files for completeness.

IMA should also consider the use of the homeless indicator to identify homeless individuals in the program. This information would be useful for management and policymakers and any future analysis of this sub-population. IMA has indicated that it will emphasize file organization requirements, and will begin using the indicator for Alliance members.

IMA should expand its instructions on how the data should be entered into ACEDS and stress the need for accuracy. IMA supervisors should review the data entries in the fields as part of the process of approving an application.

**2.b. Training and Supervision** - We found existing procedures that were either not consistent with or missing from the IMA training materials and policy and procedure manuals. The risk is that improper determinations may be made and files may be inadequate if staff is not provided with proper reference or training materials. A lack of complete written procedures could also result in an inability to provide adequate supervision to intake workers.

IMA has written policies, procedures, and training materials that discuss many aspects of the Alliance requirements, but do not include all of the desktop steps necessary to accurately post the recipient data in the database.

Among other things, we noted that there are no written training procedures for making timely transfers to Medicaid. We also noted that the procedures for 50-64 Waiver transfers were not included.

The policy manual discusses eligibility periods of either 4 or 12 months. We found eligibility periods in the records that were inconsistent with this information. There is no discussion about other eligibility periods or allowing the period to be adjusted to conform to other programs.

**Recommendation:** IMA should consider expanding its training materials and policy and procedure manual to include all policies and procedures currently in place, as well as detailed instructions on accurately entering the records in the ACEDS database. All intake workers should receive this training, and supervisors should review the accuracy of database entries and the completeness of the paper files.

IMA has indicated that it will improve its training procedures.

**OBSERVATION #3:**
***Classification of Homeless Recipients and Verification of their Homeless Status***

**3.a. Additional Verifications for Homeless Individuals** - The regulations regarding verifications for homeless individuals are not specifically defined. The homeless population has no requirement for producing proof of residency. In our review of the 359 sample cases, there were inconsistencies in the case documentation and indications that recipients had addresses outside of the District in four homeless cases. The potential risk is that without well-defined procedures, verifications may not be performed in a consistent manner.

CDCR §3304.8 states that when the applicant or enrollee indicates that he or she is homeless, IMA may request verification of residency if it has substantial reason to believe that the applicant or enrollee is not homeless or is not a District resident.

Although IMA procedures comply with the Alliance rules, this regulation has not been clarified in writing to provide guidance on the circumstances or conditions that would require additional verifications of residency, but rather, it has been left up to the judgment of the intake worker when further verifications are required or when a case should be referred for investigation. Management's

clarification would help ensure that intake workers make consistent determinations.

In conducting our research for this report, we identified another metropolitan municipality that has compiled the verification requirements for homeless individuals into a chart that is made available for its intake workers. This chart provides guidance and alternatives and minimizes the possibility of subjective reasoning by the intake worker.

**Recommendation:** The policies and procedures should be expanded and more closely defined in writing to include specific circumstances where additional verification could be required for those who declare themselves to be homeless.

**3.b. 'Intent to Reside' Clause in the Regulations** - Currently, a written declaration of a homeless individual's intent to reside in the District is not required. The potential risk is that individuals who do not intend to reside in the District could still qualify for benefits.

CDCR §3304.7 states that IMA should not routinely require further verification of residency for homeless applicants if the applicant attests that he or she is homeless; lives in the District of Columbia; and intends to remain in the District of Columbia.

**Recommendation:** IMA should consider revising the application to include a written attestation that conforms to §3304.7.

IMA has indicated that it intends to include an 'Intent to Reside' clause in its application process.

**OBSERVATION #4:**
***Timely Transfers of Eligible Recipients from the Alliance into Other Programs:***

**4.a. Medicaid/Medicare-Eligible Recipients:** IMA does not consistently transfer U.S. citizens over 65 out of the program and into Medicaid/Medicare in a timely manner. If the transfer is not timely performed, there is an additional cost to the program that must be recouped from the MCO.

Each recipient who is a U.S. citizen should be reviewed for eligibility in Medicaid or Medicare and transferred out on his/her 65th birthday if found to be eligible. We noted that not all of these individuals qualify for these programs and some will remain in the Alliance Program.

In the database of 73,001, we identified individuals whose age ranged from the age of 65 upwards who remained in the program past their 65th birthdays, and excluded those who were not reported as U.S. citizens. We performed an analysis of the timeliness of the termination date and developed a chart showing the timeliness of the transfer to other programs, see the Appendix, Exhibit 1.

Of these, 200 were transferred while they were 65, and 249 were past the age of 65 when they were transferred. We also identified 166 who remained in the program past their 65th birthday as of November 16, 2007. We also noted that there were no written procedures to review recipients when they reached the age of 65.

IMA has reported that it is in the process of reviewing the 166 cases. Of these, 86 have been reviewed thus far, and 54 transfers have been made. IMA indicated that they will begin a monthly report on these transfers.

**Recommendation:** IMA should review all U.S. citizens who are over 65 to determine if they qualify for Medicaid/Medicare. In addition, IMA should review all recipients who are 64 and ensure that their recertification dates correspond to their birthdays.

IMA should set up systems and procedures to ensure that all qualified recipients are routinely transferred out of the program in a timely manner so that the requirement for recoupment is either minimal or not necessary.

IMA indicates that they will start updating the recipients who are age 64 so that their review will be closer to their 65$^{th}$ birthdays.

**4.b. Maximize Medicaid Reimbursement for the Childless Adults aged 50-64 Waiver Program**
Prior to February 2007, IMA did not transfer citizens between the ages of 50 and 64 to the Medicaid Waiver Program in a timely manner. If the transfers are not timely performed, there is an additional cost to the program that must be recouped.

The District has available a Section 1115 Medicaid waiver to allow childless adults between the ages 50 to 64 with specified income limits to enroll in the Medicaid Program, with a cap of 1,650 participants. Although available in June 2006, we found that IMA did not start transferring Alliance Program participants who were eligible for the waiver program until February 2007. IMA transferred over 800 Alliance Program participants to the Medicaid Program in February 2007, and has indicated that they now transfer recipients on a monthly basis.

We also noted that there were no written procedures to review recipients when they reached the age of 50 and should be reviewed for eligibility in the Medicaid 50-64 waiver program.

**Recommendation:** We recommend that IMA establish policies and procedures to ensure the timely transfer of eligible participants to the Medicaid Program.

**OBSERVATION #5:**
***Residency Verifications***

**5.a. Address Monitoring -** IMAs current procedures do not require the monitoring of addresses claimed by recipients. We identified situations where a large number of people claimed to live at the same address. The range of questionable addresses is from 33 recipients at a single address to a low of 7 recipients at an address. There is a risk that certain individuals who are not qualified based on residency may provide inaccurate residency information in order to obtain benefits.

The application form requires the disclosure of all individuals who reside at an address.

Using the database of 73,001, we developed a sub-population of individuals with a residential address in the District by eliminating all known homeless shelters, shelter-type locations, and IMA offices where homeless individuals receive their mail. This sub-population was analyzed to show how many individuals claimed the same address over the 18-month period of the ACEDS database. Details supporting this analysis are in the Appendix as Exhibit 2.

We selected a judgmental sample of 13 addresses with a range of 7 through 14 currently eligible residents in order to determine whether those claiming to live at the same address also disclosed the other people living with them. We determined that none of these individuals identified all of the others claiming the same address.

We also reviewed the 83 individuals in the sample to identify the documents used to establish residency. From this analysis, we determined that 72 of these recipients used residency letters. We determined that it is possible that some of these addresses may not be the true residence for the recipients and therefore, the recipient could have received benefits for which they are not entitled. Examples of the potential risk are illustrated below:

- One address with 13 active recipients: The application form for the 13 recipients did not disclose the other individuals residing at the address as required. There were residency letters for these recipients in the case files all signed by the same person indicating that he was the uncle, the brother, and the pastor for them. The signer of the letter and his wife were also recipients and their cases were closed in October 2007.

- Another address with 9 active recipients using the same address: The application form for the 9 recipients did not disclose the other individuals residing at the address. One individual (not a recipient) verified the address for 6 of the 9; a second individual (a recipient) verified the address for 2 of the 9.

IMA has indicated that they will monitor multiple cases at a single address and will refer questionable cases for investigation.

**Recommendation:** IMA should consider investigating the addresses for individuals where unusually high numbers of recipients reside in order to determine whether recipients are inappropriately claiming an address.

IMA should consider having a regular procedure for checking the database for the number of people claiming to live at an address and should consider conducting periodic investigations.

**5.b. Residency Letter -** We found letters with incomplete residency information. These letters increase the risk of misrepresented or omitted facts in the application and the possibility of these facts going undetected.

CDCR §3304.2.3 permits the use of a verifiable letter to confirm residency. An applicant must present a letter from a verifiable source confirming that the applicant resides in the District.

The residency verification process is limited because the current policy does not require IMA to have a standardized form for identifying residency information. IMA has stated that the verification letter is designed to establish residency only at the time of application and does not represent a verification beyond this initial date.

Our review of the 359 sample files showed 160 cases where recipients used residency letters as proof of their residency. The letters were signed by relatives in 72 instances; by friends in 23 instances; landlords in 6 instances; and the relationship was not disclosed in 58 instances. In 1 instance, the applicant signed an affidavit of residency.

To be verifiable, the document should provide sufficient information that can be verified independent of the person who signed the letter such as contacting the landlord or verifying the name, address, or ownership through District property records or other outside sources. The signer of the attestation letter should also provide proof that they reside at the address through a lease, utility bill, or other verifiable documents.

**Recommendation:** IMA should consider improving the residency letter by making it a standardized form which includes key fields that must be completed prior to the approval of eligibility. The key fields could also make the form easier to verify and would strengthen and enhance the documentation in instances where the letter is the only source of residency verification.

We also recommend that an attestation clause be used in the letter. This clause would state that the signer is providing the information so that the application can receive benefits intended only for District residents, and that the information is true and correct, and that the information is being provided under penalty of perjury.

In addition, IMA should ensure that verification procedures are performed on all residency letters prior to approval of eligibility.

**OBSERVATION #6:**
***Systems and Procedures used to Process Alliance Recipients***

**6.a. Reconciling Payments to the ACEDS Data System** - IMA and HCSNA do not perform a regular comparison of payments to the ACEDS data. We compared the November 2007 payments to the ACEDS database and identified situations where a match did not occur. We found 159 recipients whose names were not in the ACEDS database. These recipients received 214 payments out of 47,709 payments for November 2007. The risk is that errors in the ACEDS system or the payment system may go undetected and payments to the MCOs will continue for recipients.

IMA explained that a total of 275 names were not included in the database of 73,001 provided to us due to a programming error and/or due to an error in the data entry. The 159 recipients were part of this group. IMA also explained that 48 out of the159 people were eligible for the Alliance in November 2007.

HCSNA reviewed 98 of the 159 recipients missing in the database and identified that 22 recipients were active in the Alliance; 59 had been transferred to Medicaid with retroactive eligibility; 14 recipients had data entry issues and therefore did not show as Alliance recipients when they should have; and 3 were ineligible and payments were recouped on subsequent remittance advices.

**Recommendation:** The District should consider implementing a procedure for a regular comparison of the payment database and the eligibility database to identify mismatches and potential errors.

**6.b. Recipients with Eligibility Periods not in Conformity with the Established Benefit Period**
We obtained the eligibility files from the ACEDS system that maintains the eligibility data for recipients and reviewed the eligibility periods for active recipients. We determined that 15,762 recipients out of 43,452 (36.3%) had eligibility periods that differed from the 4-month and 12-month eligibility periods identified in the regulations and by IMA. When the eligibility span differs from the regulations, the risk is that payments may be made for periods where a recipient should no longer be in the program.

The regulations establish a relationship between the eligibility date and the end date/recertification date by stating that the eligibility (benefit) period can not exceed 12 months. The supporting regulations are:

- CDCR §22-3301(e) The documentation required to be provided pursuant to paragraphs (a) and (b) shall be resubmitted every twelve (12) months to the District government or its agent, or more frequently if requested by the District government or its agent, in order to continue a person's eligibility for health services.

- CDCR §3306.6 An applicant (or his or her authorized representative) must recertify on an annual basis in order to maintain his or her eligibility.

In providing its recertification policy information, IMA stated:

- A recipient qualifies for a 4-month eligibility when the person appears to qualify for Medicaid because of age or disability, but needs health insurance to access a doctor for a medical examination. Eligibility under this circumstance cannot be extended;
- A recipient qualifies for a 4-month eligibility when the person appears to qualify for Medicaid as a qualified alien, but does not have the necessary documentation and needs time to gather these documents. Eligibility under this circumstance cannot be extended;
- If not qualified for a 4-month period, the recipient is granted a 12-month eligibility period unless there is a compelling reason to grant a certification period between 4 and 12 months.

- The recertification process starts three months prior to the recertification date, at which time all cases with recertification dates are examined, letters are sent, and recipients must respond before the end date.
- Recertification dates are used for both the 4-month and 12-month eligibility periods.

We reviewed the data for the 43,452 active recipients in the ACEDS data provided by IMA for November 2007. This population included two subgroups, the 4-month and 12-month eligible recipients. We focused on two fields identified in ACEDS by IMA, the eligibility date and the recertification date.

When we compared the eligibility date and recertification date for these populations, it yielded 15,762 out of 43,452 where the eligibility period was outside of the 12-month and 4-month eligibility periods. Data supporting this analysis is in the Appendix as Exhibit 3.

**Recommendation:** IMA should review the eligibility periods for the identified cases. It should update eligibility dates; and review recertification dates so that they conform to the 4-month and 12-month policy.

IMA should consider implementing a procedure for a regular review of eligibility periods to identify situations where the benefit period does not conform to the regulations.

**6.c. Payments that Appear to be made for Inactive Recipients** - We compared the November 2007 payments to the ACEDS database and identified situations where a payment was made for recipients who appear to be inactive. We found 583 payments out of 47,709 payments where the records indicate that either the eligibility period had expired and there was also a recertification date in the past, or the case had been closed in a previous month and a payment was still made for November 2007. Situations where the payments are made after the eligibility period has expired indicate a risk that over payments may be made to the MCO.

We analyzed the November 2007 payments in order to ascertain whether any payments were made for recipients where the eligibility period had already expired as indicated by either the end-date or the recertification date. Situations where the payments are made after the expiration of benefits require efforts to recoup the payments.

**Recommendation:** IMA and HCSNA should review these records and close out all cases where the eligibility period has expired. HCSNA should attempt to recoup payments.

**6.d. More than One Payment was made for a Recipients** - We analyzed the November 2007 payment file to identify situations where multiple payments were made for a recipient. We found 249 recipients representing 1,409 payments where the payments were in excess of three, where three months should be the maximum. Situations where the payments exceed the time limits in the policies and procedures indicate a risk that over payments are may be made to the MCO.

In providing its eligibility determination process information, IMA stated:

- The maximum period for the application process is 45 days, at which time IMA must make an eligibility decision;
- When an application is approved, the eligibility is made to the first day of the month that the application was filed. In no case should the eligibility be retroactive for more than the 45-day period, or a maximum of 3 months;
- When an application is denied after the 45 day period, the applicant must reapply;
- When a recipient presents timely recertification information, the eligibility is extended for 12 months;
- When a recipient does not present recertification information, the case is closed at the end of the eligibility period. If the person returns, a new application is taken.

HCSNA reported that they reviewed 49 of the recipient and identified 502 payments requiring recoupment.

**Recommendation:** IMA and HCSNA should review these multiple payments and ensure that extra payments are not made beyond the allowable policy. HCSNA should continue to recoup payments.

**OBSERVATION #7:**
***Improvements Needed in the Enrollment Policies and Procedures***

**7.a. Proper Classification of Applicant's Medical Eligibility** - Out of the sample of 359, we noted two instances where the documents in the case file suggest that individuals who are in the Alliance Program could have qualified for Medicaid. The potential risk is that individuals may be placed in the Alliance Program that could have been in Medicaid.

Regulation §3304.2 states that eligibility for the Alliance is limited to residents who are not eligible for Medicaid.

The two exceptions were:

- The recipient was a D.C. resident who was age 65 at the time of application in 11/2006 and had an income level below 100% of the Federal Poverty Level. The documentation in the file included pay stubs; driver's license; social security number; and an alien card issued on 7/25/01. This information was sufficient to qualify for Medicaid.

- The recipient was a D.C. resident who had an alien registration card issued in 1990; a social security card; and has a minor child in the Medicaid program. These are qualifying factors for Medicaid.

**Recommendation:** IMA should consider reviewing its enrollment procedures and its case review procedures in an effort to reduce the risk of incorrect enrollment due to improper IMA determinations.

**7.b. Sufficiency of Documentation in Support of Eligibility** - Our review of the sample files indicates inadequate documentation was maintained in case files in support of enrollment decisions. The risk is that there could be incorrect enrollment determinations and errors or misrepresentations of fact by applicants and it cannot be determined by reviewing the files.

Out of a sample of 359, we noted instances where required documents were missing from the case files. Regulation §3304.4(a) allows a valid motor vehicle operator's permit issued by the District's Department of Motor Vehicles for residency verification. Regulation §3304.4(c) allows a lease for residency verification.

The exceptions noted are:

In one case, the document supporting the residency was a "Lease Agreement Highlight" form and was not an executed lease. We noted no other documents to support the residency requirement. The pay stub dated 11/22/06 indicated residency in Maryland and it showed Maryland withholding. The applicant applied 11/28/06. We referred the cast to IMA for investigation in 12/07. IMA determined that the recipient alternated between the District and Maryland but benefit dates were not provided.

In another case, we noted that an expired driver's license was used to verify residency since there was no other documentation to support residency in the file.

The status of a third recipient was questionable because in her first eligibility period (2001-2006) she sent a letter in 7/06 indicating that she had moved to Maryland. She returned to the District and reapplied in 11/06 and wrote on her application the same address that she had previously used. The intake worker's narrative indicated that she was homeless. The case was referred to IMA for investigation in 12/07. IMA determined that the recipient received benefits in Maryland from 7/06 through 6/07, and received benefits from the Alliance from 11/06 through 7/07.

We noted other instances of missing or inadequate records/verifications:

- There was no income information obtained for the spouse although it was required;
- The utility bill that supported the residency letter was not in the name of the person who was providing the verification of residency;
- A recertification letter was blank;
- The same form letter from a shelter was used twice with the date changed;
- Application forms and recertification letters were not in the file;
- An eligibility date was established one month prior to the application date;
- Data found in the files did not correspond with the same data in the ACEDS system.

**Recommendation:** IMA should consider more closely adhering to its policies and procedures over file maintenance and should encourage uniform file organization. We suggest that they consider using a checklist of recipient information. In addition, management should also consider the following:

- Supervisory staff should conduct case reviews to identify areas prone to repeated errors and to ensure intake worker accountability;
- Providing regular comprehensive training sessions for eligibility intake workers in order to identify and address potential risk areas;
- Performing random statistical case file reviews to determine completeness of files and accuracy of enrollment.

# APPENDIX

**EXHIBIT 1**

## Analysis of Timely Transfer to Other Programs
## Recipients who are Age 65 Or Older
## (See Observation #1)

| Recipients who are U.S. Citizens who have been Transferred out of the Alliance | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Age at Termination | Month of Termination | | | | | | | | |
| | Jun. 2006 | Jul. 2006 | Aug. 2006 | Sep. 2006 | Oct. 2006 | Nov. 2006 | Dec. 2006 | Jan. 2007 | Feb. 2007 |
| 65 | 12 | 4 | 10 | 10 | 3 | 5 | 16 | 13 | 12 |
| 66 | 8 | 10 | 11 | 12 | 19 | 12 | 18 | 4 | 9 |
| 67 | 5 | 7 | 3 | 3 | 3 | 4 | 2 | 1 | 0 |
| 68 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 |
| 69 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| 70 & Over | 0 | 1 | 2 | 5 | 3 | 4 | 2 | 2 | 2 |
| **Total Transfers** | **26** | **22** | **26** | **31** | **29** | **25** | **39** | **21** | **23** |

| Recipients who are U.S. Citizens who have been Transferred out of the Alliance | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Age at Termination | Month of Termination | | | | | | | | |
| | Mar. 2007 | Apr. 2007 | May 2007 | Jun. 2007 | Jul. 2007 | Aug. 2007 | Sep. 2007 | Oct. 2007 | Nov. 2007 |
| 65 | 11 | 9 | 15 | 13 | 13 | 16 | 18 | 9 | 11 |
| 66 | 4 | 6 | 4 | 8 | 4 | 4 | 3 | 5 | 0 |
| 67 | 2 | 1 | 4 | 6 | 1 | 2 | 0 | 1 | 0 |
| 68 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| 69 | 0 | 0 | 2 | 2 | 1 | 0 | 0 | 1 | 0 |
| 70 & Over | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 7 | 0 |
| **Total Transfers** | **20** | **20** | **30** | **32** | **22** | **25** | **24** | **23** | **11** |

## Analysis of U.S. Citizens who are 65 and Older
## Who Remain in the Alliance

| Active Recipients who are U.S. Citizens in the Alliance | |
|---|---|
| Age as of November 1, 2007 | No. |
| 65 | 83 |
| 66 | 26 |
| 67 | 13 |
| 68 | 7 |
| 69 | 4 |
| 70 & Over | 33 |
| **Total Still Active in the Alliance:** | **166** |

**EXHIBIT 2**

## Analysis of Individuals Claiming a Specific Address Excluding Recipients Grouped as Homeless (See Observation #5)

| Number of People Claiming Same Address | Total Individual Addresses in This Category | Number of Recipients Represented |
|---|---|---|
| 33 | 1 | 33 |
| 32 | 1 | 32 |
| 28 | 1 | 28 |
| 27 | 1 | 27 |
| 23 | 1 | 23 |
| 22 | 4 | 88 |
| 20 | 2 | 40 |
| 19 | 3 | 57 |
| 18 | 2 | 36 |
| 17 | 4 | 68 |
| 16 | 2 | 32 |
| 15 | 6 | 90 |
| 14 | 14 | 196 |
| 13 | 15 | 195 |
| 12 | 18 | 216 |
| 11 | 36 | 396 |
| 10 | 58 | 580 |
| 9 | 107 | 963 |
| 8 | 144 | 1,152 |
| 7 | 226 | 1,582 |
| 6 | 384 | 2,304 |
| 5 | 575 | 2,875 |
| 4 | 1,099 | 4,396 |
| 3 | 2,256 | 6,768 |
| 2 | 6,771 | 13,542 |
| 1 | 27,615 | 27,615 |
| **Totals** | **39,348** | **63,334** |

**EXHIBIT 3**

**Analysis of Eligibility Periods**
**(See Observation #6)**

*Cases that were Identified as being in the Recertification Process:*

The ACEDS system maintains eligibility dates and recertification dates. When the recertification process begins three months before the actual recertification date, the system replaces the recertification date with a "0." During this process, payments continue to be paid if a "0" is in this field. If recertification is not completed by the recertification date, the case should be closed out.

All records with a "0" in the recertification field were extracted from the database that was provided. We examined the eligibility dates to identify when coverage started and when the recipient should be recertified and identified recipients with eligibility dates from December 1, 2006 through February 1, 2007 as cases conforming to the stated procedures.

We also identified the following non-conforming cases:

| | |
|---|---|
| Cases in recertification where eligibility dates ranged from April 1, 2007 (recertification should be March 31, 2008) to November 1, 2007 (recertification should be October 31, 2008). These cases were outside the normal 12-month range: | 218 |
| Cases in recertification where eligibility dates ranged from February 1, 2006 (recertification should be January 31, 2007) through October 1, 2006 (recertification should be September 30, 2007). These cases are still in the recertification process but should have been closed by October 31, 2007 | 971 |

(In addition to the identified cases, we found 1,273 situations where the case should have been in the recertification process based on the eligibility date but this status was not indicated. These are cases with eligibility dates from December 1, 2006 through February 1, 2007 that show a recertification date instead of a "0" in the recertification field. These cases are included in the discussion below.)

*Cases where the Recertification Date does not Conform to the Stated Policy:*

The stated policy is that recipients are eligible for a 12-month period and must recertify annually. Recertification dates in this group range from November 2007 through November 2008. (Some recipients are only eligible for 4-month periods. These cases are situations where the recipient appears to be eligible for Medicaid but needs the Alliance in order to obtain a doctor's evaluation. These cases are discussed below.)

| | |
|---|---|
| Recertification date is less than 4 months from eligibility date. Reasons for periods shorter than 4-months were not identified: | 278 |
| Recertification date is more than 4 months from eligibility date, but less than 12 months. Reasons for non-conforming periods were not identified: | 3,776 |
| Recertification date is more than 12 months from eligibility date, but less than 24 months. Reasons for non-conforming periods were not identified: | 5,233 |
| Recertification date is 24 months from eligibility date. The most likely reason for a non-conforming period was that the eligibility date was probably not updated when recipient recertified. In some cases, we noted that this explanation did not explain the situation: | 3,788 |
| Recertification date is more than 24 months from eligibility date. Reasons for non-conforming period were not identified: | 1,201 |

*Other Issues with Recertification Dates:*

| | |
|---|---|
| Recertification date is too far in the future. No date should be more than12 months from November 2007, or October 2008. Recertification dates in this group range from December 2008 to January 2009: | 211 |
| In some situations, recipients are eligible for a 4-month period so that they can complete the requirements for Medicaid. Those with a 4-month eligibility are not permitted to recertify and should have an end-date. For those with 4-month eligibility periods, we found: | |
| Cases with a "0" showing that recertification is in process: | 39 |
| 4-month case with a recertification date of November 2007. This case should have an end-date rather than a recertification date because 4-month cases should not be recertified: | 1 |
| | 6 |
| Eligibility date in December 2007, no recertification date has been entered: | |
| The eligibility date, November 1, 2007 or December 1, 2007 is the same as the recertification dates of November 30, 2007 or December 31, 2007 giving the recipient only one month of eligibility: | 34 |
| The recertification date is before the eligibility date: | 1 |
| No recertification date, field contains 99999999, which is an incorrect code: 4 show current eligibility periods; 1 shows it should have been closed: | 5 |
| **Total of all Cases with Inconsistent Recertification Dates:** | **15,762** |

# RESPONSES FROM IMA TO THE OBSERVATIONS

Government of the District of Columbia
Department of Human Services
Income Maintenance Administration

MEMORANDUM

TO: Dave Chandra, Program Analyst (OCA)

CC: Bert Smith & Company
Julie Hudman, Program Manager (OCA)
Clarence Carter, Director (DHS)
Robert Maruca, Director (MAA)

FROM: Sharon Cooper-DeLoatch, Administrator (IMA)

DATE: February 25, 2008

RE: Response to Fifth Iteration of the Bert Smith Draft Report

---

IMA is providing feedback on the fifth draft of Bert Smith's report, "Review of the Income Maintenance Administration Enrollment/Eligibility Verification Process for the DC Healthcare Alliance Program". Like the previous drafts, IMA is providing extensive comments to assist Bert Smith in producing a sound and accurate report, which IMA and the District government can use to strengthen the program. This memo will reiterate several of our global observations from previous comments, focus on three specific report observations IMA feels are substantially inaccurate and misleading, and again identify specific factual issues with the report.

As IMA has mentioned in past feedback memos, the report has identified some process and practice-related issues, which we are working on addressing. The report still does not fundamentally answer the questions of whether or to what degree IMA is incorrectly enrolling individuals in the Alliance. Rather, by pointing out a series of potentially problematic issues, the report implies problems with the enrollment/eligibility process. The reader of the report could easily extrapolate some of the quoted numbers to understand them to be ineligible individuals enrolled in the program. One other issue of framing, which should be carried through the report is that of the two universes of cases pulled (63,376 and 73,001), include individuals who were enrolled by both IMA and Chartered Health (and then converted). Clearly, IMA did not perform the initial eligibility determination for any of the cases, which were converted – well over half of all cases looked at – a statistically significant amount. This impacts, to a degree, all of the

findings – and is certainly important for context. Also, it is important to articulate that not all of those cases are currently open cases, where individuals are receiving benefits.

There are three observations in the report, which IMA feels strongly are inaccurate and need to come out. Observation 6 "Recipients with Eligibility Periods not in Conformity with the established Benefit Period" is simply wrong. We have tried to articulate this in each of our responses and meetings. When cases were converted from Charter, the existing recertification date was maintained. This was done at the request of the HCSNA. However, the eligibility start date would be a reflection of the date of conversion. So, from the very beginning, it would not be possible to compare those two dates (recertification date and eligibility start date) to determine whether the appropriate certification period was assigned. For example, a case converted in March 2006 might have a Charter-assigned recertification date of September 2006. That date would have been retained upon conversion. However, the start date would have 03/06 and the recertification date would have been 09/2006 – a difference of seven months, but still correct.

Furthermore, in order to correctly determine certification periods assigned by IMA since the conversion, Bert Smith would have needed the application date or last recertification date. Comparing that date to the recertification date would have allowed the auditor to measure the length of the certification period assigned by IMA. The last application/recertification date was not requested by the auditor and, therefore, not supplied. Despite IMA's offer to assist in identifying the appropriate ACEDS data elements for what the auditor intended to evaluate, the auditor used an ACEDS database listing and selected the data elements they wanted to receive.

Since ACEDS will automatically insert the eligibility end date if the individual fails to recertify and will transmit that data to the MMIS, there should be no concern about failing to terminate eligibility and, hence, payment. Requiring workers to enter the end date would be terribly error-prone and contrary to a practice of leaving it open. This practice has been instilled in our labor force in order to satisfy the Salazar court order requirements. Finally, requiring the entry of unnecessary contiguous segments of eligibility uses up limited space in the MMIS system which can only store eight (8) segments of eligibility. This entire finding should be eliminated from the report.

The second observation, which needs to come out of the report concerns the 50-64 Waiver. Bert Smith implies that IMA in some way failed to move Alliance individuals to this program until February 2007. In fact, IMA was not permitted by MAA to move anyone until February 2007 when the cap was raised by MAA. Since then, IMA has moved Alliance recipients to this program based on available slots every month. Attached is an e-mail trail which supports IMA's contention that this observation needs to be deleted.

Finally, as IMA has articulated in all of the previous memos, the Observations surrounding payments need to be deleted. This iteration of the report no longer has examples, as previous iterations contained, but rather gross numbers. It is greatly

concerning to IMA that this remains in the report, as IMA offered specific documentation to show that the specific examples used to support this contention in past reports were wrong. In fact, the use of the examples by Bert Smith demonstrated that Bert Smith did not understand the payment. Simply stripping the examples from a finding and using gross numbers does not support the contention being made. If Bert Smith keeps this in the report, concrete examples must be provided. This is especially relevant in this observation, in that one of the examples provided in a past report contended that nine payments were made in one month. In fact, upon a correct reading of the case, one payment was made for November 2007, and eight were recoveries, including a recovery of the November 2007 payment.

Other specific points:

Page 17 last ¶: IMA has located the last case, and has contact Bert Smith to review it.

Page 18 bullet #2: It is unclear to the reader why the 47 cases were "questionable". It should be clarified that the cases were not referred to IMA to investigate, but rather to bump against the Maryland public assistance data base. The point of the audit was for the auditor to identify whether there were cases which were incorrectly enrolled. Again, even if there is overlapping eligibility, there is no evidence that when the individual was enrolled in the Alliance he or she was not a bona fide resident of the District.

Page 19, second series of bullets: should be clarified to inform the reader that, in accordance with existing regulations, IMA does not determine the authenticity of the verification documents provided by the consumer. In that same section, "employment-related income" should be defined. Pay stubs are the usual form of "employment related-income".

Page 21 ¶ 2: The last part of the second sentence (..."however, they also allows (sic) individuals 45 days to complete the application process.") as it confuses the reader, and dose not make sense.

Page 21 last paragraph: This paragraph is misleading when it states that the CFR allows exceptions to the 45 day rule. In fact there are two exceptions in CFR § 435.911 (c): 1) when the agency cannot reach a decision because the applicant or an examining physician delays or fails to take the required action; or 2) when there is an administrative or other emergency beyond the agency's control." If an applicant turns in all of his or her verifications within the 45 day period, there is nothing in the exception clause which applies. This section needs to be rewritten to reflect this fact.

Page 23 first bullet: The number of duplicates with overlapping periods is very important in the context of this issue. There are many reasons that there may be an individual entered twice, which do not compromise the integrity of the program. If there is one open case and one closed case, there is no duplicate payment. However, it is important to know when there are overlapping periods.

Page 23 fifth bullet: This is wrong. ACEDS will not allow more than ten digits in the telephone number field.

Page 23 last bullet. This bullet (We found 56 files in our sample where the application or recertification forms were missing) needs to be flushed out. While important in the context of the job IMA does at file management, it is only relevant in the context of this audit for cases in which IMA completed the initial application – or a recertification. If these were from converted files, the fact that an application is missing is not relevant to the job IMA is doing vis-à-vis enrollment/eligibility determination.

Page 25 (Observation #4). IMA has started a monthly report of this universe of individuals. We have also completed the review of the entire 166 cases. Fifty six of the cases were transferred to Medicaid and the remaining 110 were retained in the Alliance, as they were ineligible for Medicaid.

Page 26 (Observation #5). IMA committed to running a matrix of multiple recipients at the same address and taking appropriate action based on the findings. After running the first matrix report and reviewing based on the findings of the auditors it was found that, in fact, the auditor's findings were incorrect in many instances. IMA is only in the initial stages of investigating this, but preliminary investigation informs us that a great many of the addresses cited were, in fact, apartment buildings – in some cases very large apartment buildings.

Page 31 (Observation #7): This specific chart needs to be included. The Chart provided in our response to IMA's last draft is relevant, but also wrong in parts – and need to be fixed.

- Case #246760 is only relevant if we know that the individual did not live in the District at the time eligibility was determined.
- Case # 222775 is wrong. The auditor used the YTD earnings from one pay stub, and what IMA enters is the actual income received in the last 30 days. This is according to IMA policy. While close, this individual qualifies for the Alliance.
- Case # 455028 and #458984, the auditor never determined whether the individual lives in the District or in Maryland at the time of application. It is only an error if the individuals were living in Maryland at the time of application.

Page 36 Chart: This chart is wrong. See response on recertification periods.

Attachment